

**PERMISSION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION WITH  
ST. CHARLES COMMUNITY COLLEGE (SCC)**

I, \_\_\_\_\_, authorize  
*Name of Student*

- Christina Jackson, LPC  
 Erica Outtrim, LPC  
 Beth Finders, Dean of Student Success

to release to and/or obtain from another specified party certain information as specified below:

**TO WHOM/FROM WHOM (Check only one item below):**

Release to       Obtain from       Exchange with

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone

**SPECIFIED TYPE OF INFORMATION TO BE DISCLOSED/EXCHANGED:**

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological Evaluation   | <input type="checkbox"/> Social History                 |
| <input type="checkbox"/> Psychiatric Evaluation   | <input type="checkbox"/> Medications Prescribed         |
| <input type="checkbox"/> Psychiatric/Medical History  | <input type="checkbox"/> Risk of Harm to Others         |
| <input type="checkbox"/> Risk of Harm to Self   | <input type="checkbox"/> Summary of Completed Treatment |
| <input type="checkbox"/> Recommendation concerning the student's ability to return to the college environment | <input type="checkbox"/> Other: _____                   |

The reason the request is being made is to facilitate an individualized and objective assessment of the student's ability to safely participate in college sponsored classes and activities.

This authorization will remain in effect until \_\_\_\_/\_\_\_\_/\_\_\_\_.

This authorization should expire 90 days from the date of the consent for one-time releases – or – one year when the release of information is required for ongoing service provision by a contracted or cooperating service provider.

This consent is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance to it. The revocation must be submitted in writing.

I may request to review and copy the information disclosed. I understand and agree that a reproduction of this authorization will be valid and accepted with the same authority as the original. I have been advised of any consequences that may result from a refusal to consent. Specifically, the Behavioral Intervention Team will formulate a recommendation for the Dean of Student Success without the benefit of the evaluation information. There may also be consequences under the Student Code of Conduct.

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date